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Manitoba Ombudsman

February 14, 2019

The Honourable Chief Judge Margaret I. Wiebe
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

RE: Inquest into the Death of Wilfred Lesley Asham

Dear Chief Judge Wiebe:

As you are aware, it is the practice of our office to follow up on inquest recommendations when they relate to a Manitoba government department, agency or municipality. I am writing to advise you of the results of the inquiries made by our office concerning the recommendations made by the Honourable Judge Heinrichs in his report regarding the Inquest into the Death of Wilfred Lesley Asham, issued on October 12, 2012.

BACKGROUND

On September 2, 2007, Wilfred Asham and another male were apprehended by members of the Winnipeg Police Service as they attempted to flee from a stolen vehicle. While in custody at the Public Safety Building, Mr. Asham collapsed. Despite resuscitation attempts by the Winnipeg Fire Paramedic Service and emergency staff at the Health Sciences Centre, Mr. Asham was pronounced dead. An autopsy report concluded that the immediate cause of death was "probable cardiac arrhythmia".

INQUEST RECOMMENDATIONS

In the inquest report, the judge made two recommendations:

Recommendation 1

It is recommended that all police forces develop, maintain and distribute to all their officers a clear policy which sets out when and in what circumstances someone taken into police custody should be medically cleared by a paramedic or emergency room personnel before being taken to a police station or lockup.

Recommendation 2

It is recommended that Automated External Defibrillators ("A.E.Ds") be installed at every police station and at every location where someone is taken into police custody, is held or lodged, even temporarily.

Judge Heinrichs also suggested, without making a formal recommendation, that having cameras in all prisoner areas of police stations would afford an objective record of all interactions between police officers and those in their custody (subject to the privacy rights of individuals in custody).

RESPONSE TO INQUEST RECOMMENDATIONS

From January 2013 onward, our office corresponded with Manitoba Justice to determine what actions could be taken by the department to implement Judge Heinrichs' recommendations.

In 2018, our office began reassessing our processes of monitoring inquest recommendations under the Fatality Inquiries Act. Manitoba Ombudsman has since entered into a Letter of Understanding with Manitoba Justice, which states the following:

> When an inquest recommendation is directed to police services generally in the Province of Manitoba, Manitoba Ombudsman will communicate with Manitoba Justice (Policing Services and Public Safety). Manitoba Justice may then distribute a Manitoba Police Information Note (MPIN) to police services province-wide. The MPIN will advise all police services of the recommendations made in the inquest. Due to time and resource constraints, neither Manitoba Ombudsman nor Manitoba Justice are able to follow up with all province-wide police services or collect information from all police services regarding recommendation implementation.

It was also agreed that neither Manitoba Justice nor Manitoba Ombudsman have jurisdiction to follow-up on recommendations directed to federal bodies, such as the Royal Canadian Mounted Police.

On January 31, 2019, our office received Manitoba Justice's final response to the recommendations in this matter. The department advised that on November 1, 2012, the Executive Director of Policing Services and Public Safety distributed an MPIN to all police chiefs. The MPIN set out a brief synopsis of the inquest report and included the two

recommendations made. It also included the suggestion made by Judge Heinrichs concerning the installation of cameras in police stations to record interactions between police officers and detained persons. A copy of the MPIN issued in this matter is enclosed with this report.

CONCLUSION

Given that the recommendations have been responded to by Manitoba Justice, our office is concluding our monitoring of this matter at this time.

Please note that an electronic copy of this report will be posted on the Manitoba Ombudsman website at www.ombudsman.mb.ca.

Yours truly,

Marc Cormier
Acting Manitoba Ombudsman

cc: Dave Wright, Deputy Minister, Manitoba Justice
Dr. John Younes, Chief Medical Examiner, Manitoba Justice

Enclosure

Manitoba Justice

Criminal Justice Division

Manitoba Police Information Note

Wilfred Asham Inquest 11/01/12

Report on an Inquest into the death of Wilfred Asham Judge Robert Heinrichs - Released October 17, 2012

Mr. Wilfred Asham died on September 2, 2007 while in the custody of the Winnipeg Police Service at the Public Safety Building in Winnipeg, MB on charges related to theft of a stolen vehicle. The cause of death was identified as probable cardiac arrhythmia. The Chief Medical Examiner directed an Inquest into the death of Mr. Asham under *The Fatality Inquiries Act*. The Inquest was held in April, 2012 by provincial court Judge Robert Heinrichs. A final report on the Inquest was released on October 17, 2012. Three recommendations were made by Judge Heinrichs in the final report, based on evidence reviewed during the Inquest.

Recommendation #1: It is recommended that all police forces develop, maintain and distribute to all of their officers a clear policy which sets out when and in what circumstances someone taken into police custody should be medically cleared by a paramedic or emergency room personnel before being taken to a police station or lockup.

Recommendation #2: It is recommended that Automated External Defibrillator ("A.E.Ds") be installed at every police station and at every location where someone is taken into police custody, is held or lodged, even temporarily.

The Judge recommended that the A.E.D.'s be installed, not only at police stations, but at every location where someone taken into police custody is held or lodged. This would include rescue facilities where people are lodged under *The Intoxicated Persons Detention Act,* Correctional Centres where police hold or lodge arrestees, and all temporary holding facilities in rural and northern communities. This would include any buildings or locations where Band Constables hold someone while waiting for the R.C.M.P. to arrive.

Further to this recommendation, the Judge noted that "all police officers and those employed by police detachments to guard someone taken into custody need to have adequate training in the use of an A.E.D. in the event of an emergency".

Additional Recommendation: Subject to respecting the privacy rights of someone in custody, having cameras in all prisoner areas of police stations would afford an objective record of all interactions between police officers and those in their custody.

This is listed as an additional recommendation as the Judge noted having surveillance cameras in place at a police station would not necessarily prevent a similar death. For this reason it is technically outside of the mandate of the Inquest to make such a recommendation.

The inquest report can be found at the following URL: www.manitobacourts.mb.ca/pdf/inquest_wilfred _asham.pdf

Prepared by: Crystal Gartside, Senior Policy Analyst, Policing and Public Safety

MPIN issued by: *Glen Lewis, Executive Director of Policing Services and Public Safety*

Manitoba Police Information Notes **are prepared by the Criminal Justice Division to disseminate information to police services on new initiatives, training opportunities, as well as legislative and other developments related to policing.**